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John T. Donovan, Esquire
Rawle and Henderson
The Widener Building
One South Penn Square
Philadelphia, PA 19107

RE: **ROBERT REVAK**
Your File No. 4042-160

Dear Mr. Donovan:

At your request I interviewed and examined Mr. Robert Revak in my office at the Pennsylvania Hospital on August 31, 2006. Mr. Revak appeared promptly in the company of Ms. Veronica Golden who presented herself as a paralegal with the firm of Freedman and Lorry. Prior to initiating the interview and examination I explained to Mr. Revak that the purpose of the visit was not for me to undertake his care or recommend therapy. He stated that he recognized such and that I was seeing him for the legal matter at hand.

Prior to the interview and examination I reviewed records which you had previously forwarded to me. These included material from Thomas Jefferson University as well as Methodist Hospitals. I reviewed records from NovaCare as well as the offices of Drs. Salvo, Sher, Winokur, Mandel and Bennett. Finally, I reviewed a deposition provided by Mr. Revak on June 1, 2006.

Mr. Revak presented himself as a 69 year old, currently unemployed, ambidextrous individual who uses his left hand for writing and his right for most else. He denies medication allergies and denies the current use of prescription medications. He takes either Tylenol or aspirin for either left foot or right hip pain as well as neck discomfort. He smokes about a pack of filter tip cigarettes a day and denies the use of alcohol over the course of the last 2-3 years.

His only hospitalizations as an adult were subsequent to the incident in question, those occurring at Jefferson and Methodist.

His family history is not directly contributory.

He finished high school and I did not inquire as to his early work career as he stated that he had been working as a stevedore for thirty years or more prior to September 2002.

In so far as other injuries are concerned, the only one that he recalled other than of the September 2002 event was an episode in a New Year's club where he fell and banged his head. He was not sure when this had transpired but recalls being taken to a hospital but not being kept overnight.

I asked him as to which physicians he might be seeing on a regular basis. He recalled the names of Dr.

Sher and Winokur and had to be reminded about Dr. Salvo.

In so far as his activities of daily living are concerned, he has not been working but spends his day walking, watching TV and doing less in the way of usual repair work around the house. He claims to spend much of his time breaking down and rebuilding tools. He claims to have played baseball and football with his grandchildren in the past but no longer. He also claims to have developed a hernia secondary to the physical therapy which he underwent. It does not bother him and he has demurred on surgery.

The remainder of his medical review of systems is benign.

Mr. Revak claims that on September 8, 2002 he was "discharging" freight. A large lumber platform of some sort was being lowered, one which the stevedores would turn and direct. He was pushing one of these objects when a sling broke and a "300-400 pound" object struck him from the front. He claims to have lost consciousness for a half hour to an hour, awakening when the rescue squad was present. He recalled the ambulance ride and admission to Jefferson and recalls his time at Jefferson and Methodist.

I then asked him whether or not any of the problems which he had been having difficulty with soon after the incident in question had subsequently improved. He said none had.

I then asked him what problems he was currently having which he would attribute to the incident in question.

He states that he has right posterior inferior skull pulsation which is notable only when relaxing and not while more active. It began about a year and a half after the accident and has not improved. He relates it to the incident despite the hiatus.

He complains of neck pain, particularly with diminished range of motion. He says that this began immediately after the accident and has not improved. He has difficulty in turning his head to the left, both in terms of speed as well as range of motion. He has no difficulty looking up and down.

He complains that his left arm is "not the same" as his right. He complains that it is weak, predominately in elbow flexion and feels that the right arm is overall distinctly stronger. He complains of a numb sensation with loss of feeling in the second, third and fourth digits on the left hand, both palmar and dorsal. He complains of paresthesias at all times in that same distribution without exacerbation at night. He feels that both the arm weakness and altered sensation have not changed recently. He claims that these symptoms were present immediately after the accident.

He complains of right hip pain, aggravated predominately when he walks more than a mile to a mile and a half. He does not have pain when rolling over onto his right side.

He complains that he senses a "bump" in the area of the hernia.

He complains of left lower leg numbness as well as difficulty with the use of the leg. The numbness extends anteriorly from below the knee to the ankle, mainly medially, in the distribution of the injury-associated skin trauma.

He complains of difficulty with his balance. He states that some physicians have claimed that this is coming from his head although he denied problems there with during the first two years after the incident, during which time he was up and around. He claims to have had difficulty walking during the first two years although that was not evident from the records. He says that this balance problem is not rotational or a sense of tilting. He has no dizziness in his head or spinning. When walking he tends to drift to the right and he feels that it is secondary to protecting his left ankle.

When asked about his memory he said that he has no difficulty running errands and can recall messages. He was unsure as to the presence or absence of any cognitive dysfunction.

The remainder of his neurologic and medical review of systems was entirely benign. He wears bifocals without difficulty. He has a history of tinnitus in the past but less so now.

Examination: He was alert and oriented to person and Philadelphia but thought it was early August. He had difficulty remembering three objects after five or six minutes but his attention appeared to be distracted. He was aware of president Bush and that a war was going on in Iraq and Israel but was unaware of any previous presidents. He had difficulty with serial 7's and became frustrated with serial 3's. He had no difficulty with repetition, naming or spontaneous speech.

His blood pressure was 140/80. He stood about 5'8" and weighed in the high one teens. He claims to have lost approximately 15 pounds subsequent to the injury. Scarring as noted on the medial left lower leg.

He had a slight decrease in volitional range of motion of the neck to the left but not to the right. His sitting root test was negative. His visual acuity was J1 bilaterally with full fields to finger confrontation, normal appearing fundi, full extraocular movements and pupils at 3 mm., round, reactive to light and to accommodation. Sensory and motor function about the face were normal and hearing was intact to whispered speech.

Motor examination revealed giving way of most of the upper extremity muscles without evidence of atrophy or fasciculations. The same was true of the distal left leg. He had nonspecific unsteadiness of the use of his limbs. His gait was slightly wide based and he favored the left side. His Romberg was positive. His reflexes were 2+ and symmetric at the biceps and radialis while his triceps was 1 on the right and absent on the left. His quadriceps reflexes were 2+ and symmetric with absent ankle jerks and his toes were downgoing. He complained of altered feeling to most modalities in the left C7 distribution as well as into the anteromedial aspect of the left lower leg, stretching about ten inches from the ankle up medially. Vibration sense was diminished up to the knees bilaterally.

Review of Records: The records which I reviewed make mention of an episode of head and neck injury which transpired in 1994 when he was intoxicated. The events at Jefferson make mention of questionable loss of consciousness according to the intake records as well as the Emergency Room sheet. His Glasgow coma scale was 15. His evaluation revealed an occipital nondisplaced fracture as well as a pelvic ramus fracture and a left medial malleolar fracture. The transfer form makes mention of memory loss but questionable loss of consciousness. He was evaluated by neurosurgery but it was not suggested that he undergo treatment for the skull fracture.

During my history taking he mentioned an episode of falling on returning from a bathroom after he had had "a couple of beers". The record from Jefferson suggests that on December 30, 2003 he had a witnessed fall with loss of consciousness, being amnestic to events after having fallen from a standing position after drinking six beers. A laceration was noted. An episode of syncope after drinking was also reported in January 2005 despite the fact that he reported to me abstinence from alcohol for 2-3 years.

The Methodist Hospital reports make mention of a forehead laceration due to injury in May 2000 and follow up evaluations and treatment in September and October 2002 subsequent to the incident at hand. Concern had been expressed about memory difficulties but neuropsychological testing was deferred and apparently has never been done. Subsequent to being discharged from Methodist he developed a problem with pulmonary embolization and required hospitalization, once again, for about a week in October 2002. He was seen in consultation by Dr. Rider on September 12, 2002. At that time he denied memory problems and recalled events right up to the accident, with his first memory that of lying on the ground. He also recalled the ER events. No mention is made, in her set of diagnoses, of cognitive difficulty. Mention was made of perhaps undertaking neuropsychological testing to rule out traumatic brain injury as an outpatient. He was seen by Dr. Sher in October. Dr. Sher makes mention of an EMG which had been performed a week previously, one suggestive of an acute left C7 radiculopathy. No mention is made of cognitive dysfunction in her consultation.

Follow up with Dr. Salvo, orthopedics, transpired between October 2002 and the earlier part of this year. Mention is made of problems with deficits in motion and strength and allusions are made to dizziness and lightheadedness, although at the present time Mr. Revak does not complain of lightheadedness or dizziness but simply says that he is off balance and veering. Dr. Salvo also reported complaints of weakness in the left upper extremity and alluded to an EMG done by Dr. Sher. As of April 3, 2006 he was continuing to complain of left leg numbness distal to the fracture and weakness of the left upper extremity, more at the elbow than in the wrist and hand.

He has continued to see Dr. Sher over the course of the last three years. Early notes make mention of improving memory loss, that as of March 2003, and ongoing complaints of imbalance. Personality changes were mentioned by the wife with whom I was not given an opportunity to speak. In so far as traumatic brain injury is concerned the patient was felt to be functional, as of July 2003, and did not want to address these issues. The episode on New Year's Eve 2003 was made mention of, one requiring three stitches. In March 2004 complaints were noted of difficulty with angry outbursts and it was suggested that he had difficulty with calculations, concrete proverbs and memory dysfunction of a higher order than was suggested on my examination.

The more recent visits, those of 2006, make mention of the lumbar area raising the question, on MRI, of multilevel DDD. No disc herniation was noted nor does he have complaints of radicular pain that would suggest an etiology emanating from the low back. Dr. Sher felt that there was atrophy of the right foot intrinsics but I saw no evidence of that at the present time. Provision was made for occipital trigger point injections. He complained to her during this past year of right foot dysesthesias, not making mention to me of similar problems.

In so far as other evaluations are concerned, he was seen by Dr. Richard Bennett in April 2003 and initially by Dr. Mandel in November 2003. The first evaluation revealed a similar history with complaints of

lightheadedness and dizziness which do not appear to be problematic at this time. His examination was similar to that which I found as well and Dr. Bennett suggested that because of the lightheadedness and other physical injuries it would not be appropriate for him to return to his stevedore activity but that he might try a sedentary occupation. Mr. Revak at that time did not feel that he was experiencing impairment of his memory.

He was seen by Dr. Mandel in November 2003 complaining of his left arm, "dizziness", with complaints of veering to the right or the left and problems with the ankle, left groin and low back. His examination at that time revealed limitation of range of motion of the neck and weakness of the left C7 musculature with a slightly diminished triceps jerk. He found evidence of a superficial and deep peroneal sensory abnormality in the left lower extremity with normal calf or posterior tibial sensation. I found more in the way of vibration sense abnormality bilaterally than was noted by him. His gait was said to be unsteady. He made mention in his review of the records of a 2002 EMG study which demonstrated an acute C7 radiculopathy. He noted that the cervical disc abnormalities were age indeterminate but suggested that the EMG raised this to a more acute level. He was more concerned about a central or peripheral vestibular disturbance although dizziness is not a current complaint.

Finally Mr. Revak was seen by Dr. Mandel for an EMG in May of this year, one which documented the presence of a C7 radiculopathy and a mild left carpal tunnel syndrome.

I reviewed the reports of a series of imaging studies including those generated at Thomas Jefferson Hospital and Methodist initially. I made note of the pelvic as well as ankle fractures and the nondisplaced fracture of the occipital region. A C6-7 disc herniation was noted on an October 2002 MRI and then, recently, Dr. Sher ordered a lumbosacral MRI which demonstrated degenerative changes without acute disc herniation.

Mr. Revak's deposition testimony was, in the main, concordant with the history which he provided me.

Opinion: Mr. Revak has a number of complaints which he relates to the incident in question.

Firstly in so far as cognitive issues are concerned it is unclear to me as to whether or not he complained of memory difficulties early along. Additionally, there is no notable history of retrograde amnesia, with excellent recall up to the time of the incident in question and minimal anterograde amnesia. While he now claims to have been unconscious for a half an hour to an hour there was a question in the initial records as to whether or not he lost consciousness at all. Individuals who have such good retrograde, and such minimal anterograde, recall do not tend to complain of significant ensuing cognitive difficulty in the long term. Additionally, he reports that he is currently able to take tools apart and put them together again, suggesting some higher order of cognitive functioning. I do not think that bedside testing can be considered valid and am very much concerned about his premorbid cognitive situation. I also am concerned about his history of alcohol use, given the two episodes, at least, of alcohol use that might have lead to injury. Finally, he has suffered with at least two other episodes of head injury. It would be difficult to parse out the contribution of any one of the reported injuries to present complaints of cognitive dysfunction.

In so far as his left arm is concerned, he has give way weakness in the distribution beyond the direct distribution of the C7 musculature. He does have evidence of a dropped left triceps jerk as well as altered sensation in the C7 distribution. According to the records, this was not complained of prior to the incident

and he does not recall such difficulty. He has some ongoing difficulty with sensation there in.

He has altered sensation in the left lower extremity, mainly in the distribution of the direct injury. I would disagree that this represents a peroneal process. It starts a bit lower in the leg and does not extend around from the lateral aspect of the calf into the medial but stays in the medial aspect in the lower part of the leg. This appears to be much more likely secondary to direct injury at the level where he had some skin injury and fracture. He guards that leg rather notably.

On repeated questioning as to whether or not his gait dysfunction was secondary to dizziness in the head he claimed not and stated that he veers to the right because he is favoring his left leg. He denies rotational vertigo and/or other symptoms of such type. If he had suffered vestibular or cerebellar injury at the time of the incident in question, he should have had significant complaints of rotational or other types of vertigo immediately, gradually diminishing over time and demonstrating compensation. This is not the case and he himself claims that his gait dysfunction was not notable until two years after the incident in question, well after he was able to get up and walk around. If it had arisen from his vestibulocerebellar apparatus it should not have delayed in this manner nor present in this fashion.

He does have complaints of a left hernia and right hip discomfort concerning which I will defer to my surgical or orthopedic colleagues.

I understand that he will be undergoing neuropsychological testing. When those records are available I would be only too happy to review them if you wish.

The opinions expressed above are all held to a reasonable degree of medical certainty.

Yours truly,

David G. Cook, M.D.

DGC:ll